

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

### **I. DISPUTE**

1.
  - a. Whether there should be reimbursement for date of service 03/14/02.
  - b. The request was received on 06/26/02.

### **II. EXHIBITS**

1. Requestor, Exhibit I:
  - a. TWCC-60
  - b. HCFA-1500
  - c. TWCC-62 forms
  - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
  - a. TWCC-60 and Response to Request for Medical Dispute Resolution
  - b. TWCC-62 forms
  - c. Payment Screen
  - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. The case file does not contain additional information from the provider as required by Rule 133.307 (g) (3). The additional information was requested from the provider by the Division on 07/16/02. The provider failed to respond to the request for additional information, therefore, no requestor additional information was submitted to the carrier. The responses from the carrier were received in the Division on 07/01/02, 08/20/02, and 08/21/02 as reflected in Exhibit II. All information in the medical dispute packet will be reviewed.

### **III. PARTIES' POSITIONS**

1. Requestor: No Response

2. Respondent: Letter dated 08/19/02  
 “We have the MR100 notification and the Mr [sic] 116 that was sent to the requestor but have never received a copy of any additional documentation. The provider is billing for a pad and pump separately in order to bypass the preauthorization requirement for items over \$500.00. We believe this is inappropriate in that a code has been provided for both the pad and pump. According to the '91 Fee Schedule, usual and customary reimbursement for a Water-circulating heat pad with pump is \$603.25. The provider has been reimbursed \$603.25 for the pad and pump dispensed for the claimant [sic]...”

#### IV. FINDINGS

- Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 03/14/02.
- Per the provider's TWCC-60, the amount billed was \$494.00; the amount paid was \$380.76; the amount in dispute is \$113.24.
- The carrier denied the billed services by code:  
 “Z560 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY VALUES AS ESTABLISHED BY INGENIX. (Z560)
- The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
03/14/02	E0236-NU D0368	\$494.00	\$380.76	Z560	D0368 \$490.20	CPT descriptor; Rule 133.307 (g) (3); (A), (B), (C); MFG DMEGR (IX); MFG GI (VIII)	The provider failed to respond to the request for additional information mailed on 07/16/02, therefore, no medical documentation is included in the medical dispute packet to indicate that the services were rendered as billed. “A statement of medical necessity, along with the order or prescription appropriate for the equipment /supplies shall accompany initial claims for the rental or purchase of DME....This statement shall include the medical necessity and specify the following:...claimant's diagnosis;...prognosis...the expected duration the equipment or supplies will be required.” The provider failed to submit the statement of medical necessity for the billed service, therefore, without documentation it cannot be determined if the service was rendered as billed. Per the General Instructions. “...TWCC modifiers may differ from those published by the American Medical Association, and in submitting workers' compensation billing, only the modifiers set out in the Medical Fee Guidelines shall be used.” The modifier “NU” is not an approved MFG modifier. No reimbursement is recommended
<b>Totals</b>		\$494.00	\$380.76				The Requestor is <b>not</b> entitled to reimbursement.

The above Findings and Decision are hereby issued this 21st day of November 2002.

Donna M. Myers  
Medical Dispute Resolution Officer  
Medical Review Division

DMM/dmm